ATTACHMENT A – RFP#720C-04050-06M

STANDARDIZED COMPREHENSIVE ASSESSMENTS FORMS

1. Virginia Pre-Admission Screening Mental Illness (MI) Level II Instrument (8 Pages)
2. Virginia Pre-Admission Screening Mental Retardation (MR) and/or Related Condition (RC) Level II Instrument (7 Pages)
3. Virginia Pre-Admission Screening Dual (MI & MR or MI & RC) Diagnosis Level II Instrument (10 Pages)

Virginia PRE-ADMISSION *Screening*
Mental Illness Level II Instrument

SECTION I: IDENTIFICATION

1. Name: _____ _____ _____
   Last First MI

2. Gender: ☐ M ☐ F 3. DOB: _____ 4. Age: _____

5. Private Pay: ☐ No ☐ Yes 6. Medicaid#: _____ 7. SSN: _____

8. CSB Name: _____ 9. Evaluation Date: _____
   (Catchment Area)

10. Evaluation Location: ☐ NF ☐ Hospital ☐ Home ☐ Other (specify)_____

11. LPASC: _____ Contact Person: _____
    (Title)
    Address: _____ City: _____ State: _____ Zip: _____

    Telephone: ( ) _____

12. Per documentation in chart, does the individual have a **LEGAL GUARDIAN?** ☐ No ☐ Yes
    If "Yes", complete the following:

    Name: _____ Phone#: ( ) _____

    Address: _____ City: _____ State: _____ Zip: _____

    Relationship: ☐ Parent ☐ Child ☐ Sibling ☐ Spouse ☐ Friend ☐ Other *(specify)*: _____

13. DSM-IV Current Diagnoses: Axis I: Primary_____ Secondary _____

    Axis II: Primary _____ Secondary _____

    Axis III: Related Condition _____

SECTION II: PSYCHOSOCIAL

1. Marital status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Unknown

2. Education:

   ☐ Less than high school ☐ Some high school ☐ High school graduate
   ☐ Some college ☐ College graduate ☐ Special Education
   ☐ Unknown

3. Last full-time employment position held: _____

4. Reasons for admission *(check all that apply)*:

   ☐ Cannot manage household ☐ Fear for personal safety ☐ Isolation
   ☐ Convalescent care ☐ Financial problems ☐ No primary caregiver
   ☐ Decline in ADLs ☐ Illness/disease
   ☐ Emergency placement ☐ Other *(specify)*: _____

5. Is this person able to evacuate a building in 3 minutes unassisted? ☐ No ☐ Yes

Name: _____

SECTION II: PSYCHOSOCIAL (Continued)

6. Provide history to substantiate MI diagnosis:

_____

_____

_____

_____

_____

_____

_____

_____

_____

7. Are there current and ongoing family supports? ☐ No ☐ Yes
   Please describe:

_____

_____

_____

SECTION III: LEVEL OF FUNCTIONING

1. Basic Functional Status: *Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent*

( ) Transferring	( ) Bladder	( ) Bowel	( ) Prepares for bed
( ) Toileting	( ) Self medication	( ) Eating	( ) Dressing/undressing
( ) Bathing	( ) Personal hygiene	( ) Brushing teeth	( ) Selecting appropriate clothes

2. Advanced Functional Skills: *Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent*

( ) Housework	( ) Use of telephone	( ) Use of money	( ) Goes outdoors safely
( ) Care of clothing	( ) Use of transportation	( ) Manage finances	( ) Treat minor ailments
( ) Meal preparation	( ) Shopping	( ) Use of leisure time	( ) Monitor health status
( ) Employment	( ) Understands time	( ) Respond to emergencies	( ) Attend medical appts.

3. Cognitive skills: *Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent*

( ) Prepares for daily activities	( ) Understands 1 step instructions	( ) Stays on task
( ) Arranges for transport	( ) Understands multi-step instructions	( ) Completes assignments
( ) Expresses needs and wants	( ) Learns new skills	( ) Transfers skills

4. Sleep Pattern *(mark one)*:

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep ☐ Severely disturbed pattern

5. Ambulation: (check as needed to describe resident's ability to ambulate)

☐ Fully independent	☐ Unsteady	☐ Aids (cane/walker/assis.by 1)	☐ Wheelchair/indep.
☐ Wheelchair/assisted	☐ Chairfast or Posey support	☐ Bedfast	☐ Other (specify):_____

Name: _____

SECTION III: LEVEL OF FUNCTIONING (Continued)

6. **Assistive Devices:** Describe the extent to which corrective/adaptive/prosthetic/mechanical devices could improve the individual's functional capabilities:

_____

_____

_____

_____

_____

SECTION IV: MEDICAL HISTORY

1. **Psychotropic Medication**

Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three months.

Drug Code/Name	Purpose	Dosage	Freq	Change	Response to Rx

2. **STAT/PRN Administration of Medication**

In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to control her/his behavior?

☐ No ☐ Yes

If "yes," please indicate the medication that was administered and the behavior for which the medication was administered:

_____

_____

3. **Physician Review**

Is a physical examination completed and signed by a licensed physician in the last 12 months attached?

☐ Yes, skip Physical Assessment.
☐ No, the Physical Examination Supplement must be completed and signed by a licensed physician.

4. **Comments:**

_____

_____

_____

5. _____ ( ) _____ _____

QMHP Signature | Telephone Number | Date

Name: _____

SECTION V: PSYCHIATRIC ASSESSMENT

1. **Affective Behavior Observations**

a. Physical Features *(mark all that apply):*

☐ Clean/Tidy
☐ Careless/Dishevelled/Sloppy
☐ Makeup or jewelry
☐ Non-seasonal clothing
☐ Poor hygiene/Unwashed
☐ Normal street dress
☐ No apparent effort at personal appearance
☐ Other *(specify):*_____
☐ Well-groomed
☐ Wearing bedclothes

b. Level of Consciousness *(mark all that apply):*

☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other *(specify):* _____

c. Manner *(mark all that apply):*

☐ Warm ☐ Shy ☐ Threatening ☐ Concerned about others ☐ Outgoing nature
☐ Silly ☐ Sincere ☐ Apathetic ☐ Aggressive ☐ Sense of humor
☐ Suspicious ☐ Easily frustrated ☐ Childlike ☐ Reluctant to Respond ☐ Other *(specify)*: _____

d. Mood and Affect *(mark all that apply):*

☐ Appropriate in quality and intensity to stated themes
☐ Flat or blunted

☐ Depressed	☐ Mild	☐ Moderate	☐ Severe
☐ Anxious, fearful or worried	☐ Mild	☐ Moderate	☐ Severe
☐ Angry, belligerent or hostile	☐ Mild	☐ Moderate	☐ Severe
☐ Delusional	☐ Mild	☐ Moderate	☐ Severe
☐ Suicidal	☐ Mild	☐ Moderate	☐ Severe
☐ Homicidal	☐ Mild	☐ Moderate	☐ Severe

☐ Other *(specify):*_____

e. Form of Thought *(check all that apply):*

☐ Coherent ☐ Incoherent/Illogical ☐ Blocking ☐ Tangentiality
☐ Relevant ☐ Irrelevant/Rambling ☐ Impoverished ☐ Circumstantiality
☐ Logical ☐ Loose Associations ☐ Perseveration ☐ Pressured

f. Orientation Level *(mark one):*

☐ Oriented X3; clear at all times
☐ Oriented to person
☐ Confused at times in day
☐ Nonresponsive
☐ Oriented X3; forgetful at times
☐ Oriented to situation
☐ Confused at times at night
☐ Unable to determine
☐ Oriented to person and place
☐ Oriented to bathroom/bed
☐ Disoriented X3

g. Communication Ability *(check all that apply):*

☐ No problems ☐ Reads ☐ Writes ☐ Speech unclear/slurred ☐ Gestures/aids
☐ Inappropriate content ☐ Stammer/stutter/impediment ☐ Eye contact ☐ Unresponsive

h. Socialization *(mark all that apply):*

☐ Appropriately responds to others' initiations
☐ Appropriately initiates contact with others
☐ Inappropriate responses/interactions *(describe)*: _____
☐ Withdrawn

i. Attitude *(mark one):*

☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

Name: _____

SECTION V: PSYCHIATRIC ASSESSMENT (Continued)

2. **Chart of Behavior** *Complete the chart, based on all available information for the last 3 months, including information from the individual's medical records and staff comments:*

	Frequency		Frequency
☐ Dangerous smoking behavior		☐ Destroys property	
☐ Refuses medications		☐ Exposes self	
☐ Uncooperative diet		☐ Is sexually aggressive	
☐ Uncooperative hygiene		☐ Abuses--verbally	
☐ Refuses activities		☐ Threatens--verbally	
☐ Refuses to eat		☐ Threatens--physically	
☐ Self-induces vomiting		☐ Strikes others--provoked	
☐ Impatient/demanding		☐ Strikes others--unprovoked	
☐ Frequent/continuous yelling		☐ Talk of suicide	
☐ Wanders		☐ Suicidal threats	
☐ Tries to escape		☐ Suicidal attempts	
☐ Seclusiveness		☐ Injures self	
☐ Suspicious of others		☐ Other *(specify)*:	
☐ Lies purposefully		☐ Other *(specify)*:	
☐ Steals deliberately		☐ None	

3. **Placement in Seclusion/Physical Restraints/Behavior Change(s)**

In the last 60 days, has the individual been placed in seclusion or other physical restraints to control dangerous behavior?

☐ No ☐ Yes

If "yes," describe the behavior and type of restraints:

_____

_____

_____

4. **Comments:**

_____

_____

_____

_____

SECTION VI: DETERMINATION RECOMMENDATION

1. Name: _____ _____ _____
   Last First MI

2. SSN: _____ 3. Medicaid #: _____

4. The individual has, or may have, one or both of the following diagnoses:

   Mental Retardation? ☐ No ☐ Yes If yes, specify Level _____
   Related Condition? ☐ No ☐ Yes If yes, specify Condition _____

5. As substantiated by your evaluation, does the individual meet the DSM-IV criteria for dementia or a related disorder in the absence of a **primary major mental illness**?

   ☐ No, continue
   ☐ Yes, substantiate below

   Rationale: _____

   _____

   _____

6. As a result of a major mental disorder, the individual has functional limitations in the following areas (mark all that apply):

   a. Interpersonal functioning

      ☐ 1. Difficulty interacting appropriately/communicating effectively with other persons
      ☐ 2. A history of altercations, evictions, firing, fear of strangers
      ☐ 3. Avoids interpersonal relationships
      ☐ 4. Is socially isolated
      ☐ 5. Other (specify): _____
      ☐ 6. None

   b. Concentration, persistence and pace

      ☐ 1. Difficulty in sustaining focused attention to complete work tasks
      ☐ 2. Difficulty in sustaining focused attention to complete home tasks
      ☐ 3. Inability to complete tasks within established time period
      ☐ 4. Makes frequent errors or requires assistance in the completion of tasks
      ☐ 5. Other (specify): _____
      ☐ 6. None

   c. Adaptation to change

      ☐ 1. Difficulty in adapting to typical changes associated with work, school or family
      ☐ 2. Manifests agitation, exacerbated signs and symptoms associated with the illness
      ☐ 3. Withdraws from the situation
      ☐ 4. Requires intervention by MH or judicial systems
      ☐ 5. Other (specify): _____
      ☐ 6. None

7. As a result of a major mental disorder, the individual has required treatment within the last two years for:

   ☐ Psychiatric treatment more intensive than outpatient care
   ☐ Episodes of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officers
   ☐ None

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION (Continued)

8. Does the individual meet the DSM-IV criteria for a serious mental illness?

☐ No

☐ Yes, check at least one of the following and substantiate below (P=primary S=secondary)

P	S		P	S	
☐	☐	1. Anxiety disorder	☐	☐	8. Panic disorder
☐	☐	2. Atypical psychosis	☐	☐	9. Paranoid disorder
☐	☐	3. Bi-polar disorder	☐	☐	10. Schizoaffective disorder
☐	☐	4. Delusional disorder	☐	☐	11. Schizophrenia
☐	☐	5. Depression	☐	☐	12. Somotoform disorder
☐	☐	6. Major affective disorder	☐	☐	13. Other *(specify):*_____
☐	☐	7. Mood disorder	☐	☐	14. Other *(specify):*_____

Rationale: _____

_____

9. **SPECIALIZED SERVICES RECOMMENDATION**

Does the individual require specialized services for SMI (**Inpatient psychiatric hospitalization**) ?

☐ No

☐ Yes, Substantiate below

Rationale: _____

_____

_____

10. **MENTAL HEALTH SERVICES RECOMMENDATION**

Does the individual require mental health services of a lesser intensity? ☐ No ☐ Yes (Mark all that apply)

CURRENT MENTAL HEALTH SERVICES	RECOMMENDATIONS Continue	Discontinue	New
☐ 1. Psychiatric consultation	1. ☐	☐	☐
☐ 2. Behavior management	2. ☐	☐	☐
☐ 3. Day treatment/partial hospitalization	3. ☐	☐	☐
☐ 4. Crisis intervention	4. ☐	☐	☐
☐ 5. Outpatient psychiatric	5. ☐	☐	☐
☐ 6. Psychotropic medication management	6. ☐	☐	☐
☐ 7. Psychosocial rehabilitation	7. ☐	☐	☐
☐ 8. Targeted case management	8. ☐	☐	☐
☐ 9. Other, specify_____	9. ☐	☐	☐

Justification/comments: _____

_____

_____

_____

_____

_____

11. Print Assessor's Name: _____ Title: _____ Telephone:(_____)_____

Psychiatrist/QMHP Signature: _____ Date: _____

Name: _____

SECTION VII: DMHMRSAS OFFICE USE ONLY MI/MR AUTHORITY FINAL DETERMINATION

Meets NF Criteria ☐ Yes ☐ No

Specialized Services Determination for SMI ☐ Yes ☐ No

Mental Health Services ☐ Yes ☐ No

- ☐ 1. Psychiatric Consultation
- ☐ 2. Behavior Management
- ☐ 3. Day Treatment/Partial Hospitalization
- ☐ 4. Crisis Intervention
- ☐ 5. Outpatient Psychiatric
- ☐ 6. Psychotropic Medication Management
- ☐ 7. Psychosocial Rehabilitation
- ☐ 8. Targeted Case Management
- ☐ 9. Other, specify _____

Nursing Facility Activities ☐ Yes ☐ No

In OBRA process ☐ Yes ☐ No

Diagnosis(es) ☐ SMI ☐ MR ☐ RC ☐ MR/RC ☐ DUAL ○ MI/MR ○ MI/RC

DMHMRSAS Determination Rationale:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Comments:

_____

_____

_____

DMHMRSAS Authority: _____

OBRA Consultant Date

Telephone: (804) 371-2134 FAX: (804) 786-1836

Virginia PRE-ADMISSION *Screening*
Mental Retardation and/or Related Condition Level II Instrument

SECTION I: IDENTIFICATION

1. Name: _____ _____ _____
   Last First MI

2. Gender: ☐ M ☐ F 3. DOB: _____ 4. Age: _____

5. Private Pay ☐ No ☐ Yes 6. Medicaid #: _____ 7. SSN: _____

8. CSB Name: _____ 9. Evaluation date: _____
   (Catchment area)

10. Evaluation location: ☐ NF ☐ Hospital ☐ Home ☐ Other (*specify*): _____

11. LPASC: _____ Contact person: _____
    (Title)

    Address: _____ City: _____ State: _____ Zip: _____

    Telephone: ( ) _____

12. Per documentation in chart, does the individual have a **LEGAL GUARDIAN**? ☐ No ☐ Yes
    If "Yes," complete the following:

    Name: _____ Phone#: ( ) _____

    Address: _____ City: _____ State: _____ Zip: _____

    Relationship: ☐ Parent ☐ Child ☐ Sibling ☐ Spouse ☐ Friend ☐ Other (*specify*): _____

13. DSM-IV Current Diagnoses: Axis I: Primary _____ Secondary _____

    Axis II: Primary _____ Secondary _____

    Axis III: Related Condition _____

SECTION II: PSYCHOSOCIAL

1. Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Unknown

2. Education:
   ☐ Less than high school ☐ Some high school ☐ High school graduate
   ☐ Some college ☐ College graduate ☐ Special Education
   ☐ Unknown

3. Academic skills (check the box which best describes the resident's functional achievements):

☐ Yes	☐ No	Can read/recognize simple words
☐ Yes	☐ No	Can read/recognize 3-4 word sentences
☐ Yes	☐ No	Can read at newspaper level (approx. grade 6)
☐ Yes	☐ No	Can perform simple addition/subtraction
☐ Yes	☐ No	Can perform simple multiplication/division

4. Last full-time employment/day program position held: _____

Name: _____

SECTION II: PSYCHOSOCIAL (*Continued*)

5. **Reasons for admission** (*check all that apply*):

- ☐ Cannot manage house
- ☐ Convalescent care < 30 days
- ☐ Decline in ADLs
- ☐ Emergency placement
- ☐ Fear for personal safety
- ☐ Financial problems
- ☐ Illness/disease
- ☐ Other (*specify*): _____
- ☐ Isolation
- ☐ No primary caregiver

6. Is this person able to evacuate a building in 3 minutes unassisted? ☐ No ☐ Yes

7. Provide history to substantiate MR/RC diagnosis:

_____

_____

_____

_____

_____

_____

8. Are there current and ongoing family supports? ☐ No ☐ Yes

Please describe: _____

_____

_____

_____

SECTION III: LEVEL OF FUNCTIONING

1. **Basic Funtional skills:** *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

- ( ) Transferring
- ( ) Toileting
- ( ) Bathing
- ( ) Bladder
- ( ) Self medication
- ( ) Personal hygiene
- ( ) Bowel
- ( ) Eating
- ( ) Brushing
- ( ) Prepares for bed
- ( ) Dressing/undressing
- ( ) Selecting appropriate clothes

2. **Advanced Functional skills:** *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

- ( ) Housework
- ( ) Care of clothing
- ( ) Meal preparation
- ( ) Employment
- ( ) Use of telephone
- ( ) Use of transportation
- ( ) Shopping
- ( ) Understands time
- ( ) Use of Money
- ( ) Manage finances
- ( ) Use of leisure time
- ( ) Respond to emergencies
- ( ) Goes outdoors safely
- ( ) Treat minor ailments
- ( ) Monitor health status
- ( ) Attend medical appts.

3. **Cognitive skills:** *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

- ( ) Prepares for daily activities
- ( ) Arranges for transport
- ( ) Expresses needs and wants
- ( ) Understands 1 step instructions
- ( ) Understands multi-step instructions
- ( ) Learns new skills
- ( ) Stays on task
- ( ) Completes assignments
- ( ) Transfers skills

4. **Sleep Pattern** (mark one):

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep ☐ Severely disturbed pattern

Name:

SECTION III: LEVEL OF FUNCTIONING *(Continued)*

5. **Ambulation** (mark one):

☐ Fully independent ☐ Unsteady ☐ Aids (cane/walker/assisted by 1) ☐ Wheelchair/independent
☐ Wheelchair/assisted ☐ Chairfast or Posey support ☐ Bedfast ☐ Other (*specify*): _____

6. **Assistive Devices**: Describe the extent to which corrective/assistive/prosthetic/mechanical devices are used and/or could improve the individual's functional capabilities: _____

SECTION IV: MEDICAL HISTORY

1. **Psychotropic Medication**
Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three months.

Drug Code/Name	Purpose	Dosage	Freq	Change	Response to Rx

2. **STAT/PRN Administration of Medication**

In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to control her/his behavior?

☐ No ☐ Yes

If "yes," please indicate the medication that was administered and the behavior for which the medication was administered:

_____

_____

_____

_____

3. **Physician Review**
Is a physical examination completed and signed by a licensed physician in the last 12 months attached?

☐ Yes, skip, physical examination supplement.
☐ No, the physical examination supplement must be completed and signed by a licensed physician.

4. **Comments:**

_____

_____

_____

_____

5. _____ (_____) _____ _____
QMRP Signature Telephone Number Date

Name: _____

SECTION V: BEHAVIORAL ASSESSMENT

1. **Affective Behavior Observations**

a. Physical Features *(mark all that apply):*

☐ Clean/Tidy
☐ Careless/Dishevelled/Sloppy
☐ Makeup or jewelry
☐ Non-seasonal clothing
☐ Poor hygiene/Unwashed
☐ Normal street dress
☐ No apparent effort at personal appearance
☐ Well-groomed
☐ Wearing bedclothes
☐ Other *(specify):* _____

b. Level of Consciousness *(mark all that apply):*

☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other *(specify):* _____

c. Manner *(mark all that apply):*

☐ Warm
☐ Silly
☐ Suspicious
☐ Shy
☐ Sincere
☐ Easily frustrated
☐ Threatening
☐ Apathetic
☐ Childlike
☐ Concerned about others
☐ Aggressive
☐ Reluctant to Respond
☐ Outgoing nature
☐ Sense of humor
☐ Other *(specify):* _____

d. Mood and Affect *(mark all that apply):*

☐ Appropriate in quality and intensity to stated themes
☐ Flat or blunted

☐ Depressed	☐ Mild	☐ Moderate	☐ Severe
☐ Anxious, fearful or worried	☐ Mild	☐ Moderate	☐ Severe
☐ Angry, belligerent or hostile	☐ Mild	☐ Moderate	☐ Severe
☐ Delusional	☐ Mild	☐ Moderate	☐ Severe
☐ Suicidal	☐ Mild	☐ Moderate	☐ Severe
☐ Homicidal	☐ Mild	☐ Moderate	☐ Severe
☐ Other *(specify):* _____			

e. Form of Thought *(check all that apply):*

☐ Coherent
☐ Relevant
☐ Logical
☐ Incoherent/Illogical
☐ Irrelevant/Rambling
☐ Loose Associations
☐ Blocking
☐ Impoverished
☐ Perseveration
☐ Tangentiality
☐ Circumstantiality
☐ Pressured

f. Orientation Level *(mark one):*

☐ Oriented X3; clear at all times
☐ Oriented to person
☐ Confused at times in day
☐ Nonresponsive
☐ Oriented X3; forgetful at times
☐ Oriented to situation
☐ Confused at times at night
☐ Unable to determine
☐ Oriented to person and place
☐ Oriented to bathroom/bed
☐ Disoriented X3

g. Communication Ability *(check all that apply):*

☐ No problems
☐ Inappropriate content
☐ Reads
☐ Stammer/stutter/impediment
☐ Writes
☐ Speech unclear/slurred
☐ Eye contact
☐ Gestures/aids
☐ Unresponsive

h. Socialization *(mark all that apply):*

☐ Appropriately responds to others' initiations
☐ Appropriately initiates contact with others
☐ Inappropriate responses/interactions *(describe)*: _____
☐ Withdrawn

i. Attitude *(mark one):*

☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

SECTION V: BEHAVIORAL ASSESSMENT (Continued)

2. **Placement in Seclusion/Physical Restraints/Behavior Changes**

In the last 60 days, has the individual been placed in seclusion or other physical restraints to control dangerous behavior?

☐ No ☐ Yes

If "yes," describe the behavior changes and type of restraints, if applicable: _____

3. **Functional Assessment Summary (ICAP, ABS, etc.)**

Describe current functional status - improvement or decline. Identify any strengths or weaknesses which may impact the individual's participation in specialized services.

a. Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are fine-motor and gross motor skills.)

b. Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs and requests known. This area also assesses the individual's ability to interact with others.)

c. Personal Living (This domain pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and undressing, etc.)

d. Community Living (This area addresses skills relating to handling money, telling time, acting responsibility, preparing meals, doing laundry, etc.)

e. Broad Independence (This area addresses the individual's overall ability to take care of him/herself and interact in his environment.)

f. Problem Behaviors (Describe any behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that cause harm to oneself. Describe any behavior strategies that have been implemented and their impact on the behavior.)

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION

1. Name: _____ (Last) _____ (First) _____ (MI)

2. SSN: _____ 3. Medicaid#: _____

4. The individual has, or may have, a diagnosis of mental illness?

☐ No
☐ Yes If yes, specify diagnosis _____

5. Does the individual meet the DSM-IV criteria for mental retardation?

☐ No
☐ Yes, check at least one of the following and substantiate by completing item 6 (include copy of assessment)

☐ Mild ☐ Moderate ☐ Severe ☐ Profound

6. Cognitive test (specify): _____ Date performed: _____

Verbal IQ _____ Perf IQ _____ Full Scale IQ _____

Administered by: _____ Title: _____

7. Does the individual meet the DSM-IV criteria for a related condition?

☐ No, if the answer to question 5 was also no, stop here and sign on page 7.
☐ Yes, check at least one of the following:

☐ Autism	☐ Head Injury	☐ Muscular Dystrophy
☐ Blindness	☐ Hemiparesis	☐ Paraparesis
☐ Cerebral Palsy	☐ Hemiplegia	☐ Paraplegia
☐ Deafness	☐ Hydrocephaly	☐ Polio
☐ Encephalitis	☐ Meningitis	☐ Quadriplegia
☐ Epilepsy/seizures	☐ Microcephaly	☐ Spina Bifida
☐ Friedreich's Ataxia	☐ Multiple Sclerosis	☐ Spinal Cord Injury
☐ Other: (specify) _____		

8. Check the box that best describes the individual's functional level in each of the following areas:

	Independent	Minimal	Moderate	Unable
a. Takes care of most personal needs	☐	☐	☐	☐
b. Understands most simple commands	☐	☐	☐	☐
c. Communicates basic needs and wants	☐	☐	☐	☐
d. Is employed at a productive wage w/o long term supervision/support	☐	☐	☐	☐
e. Learns new skills w/o aggressive and consistent training	☐	☐	☐	☐
f. Generalizes trained skills to other environments w/o aggressive and consistent training	☐	☐	☐	☐
g. Demonstrates behaviors appropriate to time, situation, and place w/o supervision	☐	☐	☐	☐
h. Makes decisions requiring informed consent	☐	☐	☐	☐

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION (Continued)

9. SPECIALIZED SERVICES RECOMMENDATION

Does resident require specialized services? ☐ No ☐ Yes **(Mark all that apply):**

CURRENT SPECIALIZED SERVICES		RECOMMENDATIONS Continue	Discontinue	New
☐ 1. Behavior Skills	1.	☐	☐	☐
☐ 2. Communication	2.	☐	☐	☐
☐ 3. Community Living Skills	3.	☐	☐	☐
☐ 4. Resource Utilization Skills	4.	☐	☐	☐
☐ 5. Day Support and Habilitation	5.	☐	☐	☐
☐ 6. Education	6.	☐	☐	☐
☐ 7. Environmental Skills	7.	☐	☐	☐
☐ 8. Pre-Vocational/Sheltered Employment	8.	☐	☐	☐
☐ 9. Self-Advocacy	9.	☐	☐	☐
☐ 10. Self-Help/Personal Care	10.	☐	☐	☐
☐ 11. Social Skills Development	11.	☐	☐	☐
☐ 12. Supported Employment	12.	☐	☐	☐
☐ 13. Task Learning	13.	☐	☐	☐
☐ 14. Transportation to Specialized Services	14.	☐	☐	☐
☐ 15. Assistive Technology Evaluation	15.	☐	☐	☐
☐ 16. Assistive Technology	16.	☐	☐	☐
☐ 16a. Communication devices	16a.	☐	☐	☐
☐ 16b. Compensatory devices	16b.	☐	☐	☐
☐ 16c. Environmental control devices	16c.	☐	☐	☐
☐ 16d. Environmental modifications	16d.	☐	☐	☐
☐ 16e. Feeding devices	16e.	☐	☐	☐
☐ 16f. Wheelchair Seating/positioning	16f.	☐	☐	☐
☐ 16g. Wheelchair fitting-customized	16g.	☐	☐	☐
☐ 16h. Mobility aids	16h.	☐	☐	☐
☐ 17. Other adaptive devices (specify):_____	17.	☐	☐	☐

Rationale: _____

_____

_____

10. SERVICES OF LESSER INTENSITY

Does resident require services of lesser intensity? ☐ NO ☐ YES **(Mark all that apply)**

- ☐ 1. Adjustment needs
- ☐ 2. Basic grooming
- ☐ 3. Behavior management
- ☐ 4. Non-customized durable medical equipment
- ☐ 5. Occupational therapy
- ☐ 6. Physical therapy
- ☐ 7. Restorative nursing
- ☐ 8. Speech-language pathology
- ☐ 9. Sensory stimulation
- ☐ 10. Visual/Hearing
- ☐ 11. Other _____

11. Print Assessor's Name _____ Title _____ Telephone (____) _____

Assessor/QMRP Signature _____ Date: _____

Virginia PRE-ADMISSION *Screening*
Dual (MI & MR or MI & RC) Diagnosis Level II Instrument

SECTION I: IDENTIFICATION

1. Name: _____ _____ _____
   Last First MI

2. Gender: ☐ M ☐ F 3. DOB: _____ 4. Age: _____

5. Private Pay: ☐ No ☐ Yes 6.Medicaid #: _____ 7. SSN: _____

8. CSB Name: _____ 9. Evaluation Date: _____
   (Catchment area)

10. Evaluation location: ☐ NF ☐ Hospital ☐ Home ☐ Other (*specify*): _____

11. LPASC: _____ Contact person: _____
    (Title)

    Address: _____ City: _____ State: _____ Zip: _____

    Telephone: ( ) _____

12. Per documentation in chart, does the individual have a **LEGAL GUARDIAN?** ☐ No ☐ Yes
    If "Yes", complete the following:

    Name: _____ Phone #: ( ) _____

    Address: _____ City: _____ State: _____ Zip: _____

    Relationship: ☐ Parent ☐ Child ☐ Sibling ☐ Spouse ☐ Friend ☐ Other *(specify)*: _____

13. DSM-IV Current Diagnoses: Axis I: Primary _____ Secondary _____

    Axis II: Primary _____ Secondary _____

    Axis III: Related Condition _____

SECTION II: PSYCHOSOCIAL

1. Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Unknown

2. Education:
   ☐ Less than high school ☐ Some high school ☐ High school graduate
   ☐ Some college ☐ College graduate ☐ Special education
   ☐ Unknown

3. Academic skills (check the box which best describes the resident's functional achievements):

☐ Yes	☐ No	Can read/recognize simple words
☐ Yes	☐ No	Can read/recognize 3-4 word sentences
☐ Yes	☐ No	Can read at newspaper level (approx. grade 6)
☐ Yes	☐ No	Can perform simple addition/subtraction
☐ Yes	☐ No	Can perform simple multiplication/division

4. Last full-time employment/day program position held: _____

Name: _____

SECTION II: PSYCHOSOCIAL (Continued)

5. Reasons for admission (*check all that apply*):

- ☐ Cannot manage house
- ☐ Convalescent care < 30 days
- ☐ Decline in ADLs
- ☐ Emergency placement
- ☐ Fear for personal safety
- ☐ Financial problems
- ☐ Illness/disease
- ☐ Other (*specify*): _____
- ☐ Isolation
- ☐ No primary caregiver

6. Is this person able to evacuate a building in 3 minutes unassisted? ☐ No ☐ Yes

7. Provide history to substantiate MR/RC diagnosis:

_____

_____

_____

_____

_____

_____

8. Provide history to substantiate MI diagnosis:

_____

_____

_____

_____

9. Are there current and ongoing family supports? ☐ No ☐ Yes

Please describe: _____

_____

_____

_____

_____

SECTION III: LEVEL OF FUNCTIONING

1. **Basic Funtional skills:** *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

( ) Transferring	( ) Bladder	( ) Bowel	( ) Prepares for bed
( ) Toileting	( ) Self medication	( ) Eating	( ) Dressing/undressing
( ) Bathing	( ) Personal hygiene	( ) Brushing	( ) Selecting appropriate clothes

2. **Advanced Functional skills:** *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

( ) Housework	( ) Use of telephone	( ) Use of Money	( ) Goes outdoors safely
( ) Care of clothing	( ) Use of transportation	( ) Manage finances	( ) Treat minor ailments
( ) Meal preparation	( ) Shopping	( ) Use of leisure time	( ) Monitor health status
( ) Employment	( ) Understands time	( ) Respond to emergencies	( ) Attend medical appts.

Name: _____

SECTION III: LEVEL OF FUNCTIONING: (Continued)

3. **Cognitive skills:** *Coding 1 = Independent 2 = Verbal assistance 3 = Physical assistance 4 = Dependent*

( ) Prepares for daily activities
( ) Arranges for transport
( ) Expresses needs and wants
( ) Understands 1 step instructions
( ) Understands multi-step instructions
( ) Learns new skills
( ) Stays on task
( ) Completes assignments
( ) Transfers skills

4. **Sleep Pattern** (mark one):

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep ☐ Severely disturbed pattern

5. **Ambulation:** (check as needed to describe resident's ability to ambulate)

☐ Fully independent ☐ Unsteady ☐ Aids (cane/walker/assis.by 1) ☐ Wheelchair/indep.
☐ Wheelchair/assisted ☐ Chairfast or Posey support ☐ Bedfast ☐ Other (specify): _____

6. **Assistive Devices**: Describe the extent to which corrective/assistive/prosthetic/mechanical devices are used and/or could improve the individual's functional capabilities:

_____

_____

SECTION IV: MEDICAL HISTORY

1. **Psychotropic Medication**
Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three months.

Drugs Code/Name	Purpose	Dosage	Freq	Change	Response to Rx

2. **STAT/PRN Administration of Medication**

In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to control her/his behavior?

☐ No ☐ Yes

If "yes," please indicate the medication that was administered and the behavior for which the medication was administered:

_____

_____

3. **Physician Review**
Is a physical examination completed and signed by a licensed physician in the last 12 months attached?
☐ Yes, skip, physical examination supplement.
☐ No, the physical examination supplement must be completed and signed by a licensed physician.

4. **Comments:**

_____

_____

5. **QMRP Signature** _____ Telephone: (____) _____ Date: _____

Name: _____

SECTION V: BEHAVIORAL AND PSYCHIATRIC ASSESSMENT

1. **Affective Behavior Observations**

a. Physical Features *(mark all that apply):*

☐ Clean/Tidy
☐ Careless/Dishevelled/Sloppy
☐ Makeup or jewelry
☐ Non-seasonal clothing
☐ Poor hygiene/Unwashed
☐ Normal street dress
☐ No apparent effort at personal appearance
☐ Well-groomed
☐ Wearing bedclothes
☐ Other *(specify):* _____

b. Level of Consciousness *(mark all that apply):*

☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other *(specify):* _____

c. Manner *(mark all that apply):*

☐ Warm
☐ Silly
☐ Suspicious
☐ Shy
☐ Sincere
☐ Easily frustrated
☐ Threatening
☐ Apathetic
☐ Childlike
☐ Concerned about others
☐ Aggressive
☐ Reluctant to Respond
☐ Outgoing nature
☐ Sense of humor
☐ Other *(specify):* _____

d. Mood and Affect *(mark all that apply):*

☐ Appropriate in quality and intensity to stated themes
☐ Flat or blunted

☐ Depressed	☐ Mild	☐ Moderate	☐ Severe
☐ Anxious, fearful or worried	☐ Mild	☐ Moderate	☐ Severe
☐ Angry, belligerent or hostile	☐ Mild	☐ Moderate	☐ Severe
☐ Delusional	☐ Mild	☐ Moderate	☐ Severe
☐ Suicidal	☐ Mild	☐ Moderate	☐ Severe
☐ Homicidal	☐ Mild	☐ Moderate	☐ Severe

☐ Other *(specify):* _____

e. Form of Thought *(check all that apply):*

☐ Coherent
☐ Relevant
☐ Logical
☐ Incoherent/Illogical
☐ Irrelevant/Rambling
☐ Loose Associations
☐ Blocking
☐ Impoverished
☐ Perseveration
☐ Tangentiality
☐ Circumstantiality
☐ Pressured

f. Orientation Level *(mark one):*

☐ Oriented X3; clear at all times
☐ Oriented to person
☐ Confused at times in day
☐ Nonresponsive
☐ Oriented X3; forgetful at times
☐ Oriented to situation
☐ Confused at times at night
☐ Unable to determine
☐ Oriented to person and place
☐ Oriented to bathroom/bed
☐ Disoriented X3

g. Communication Ability *(check all that apply):*

☐ No problems
☐ Inappropriate content
☐ Reads
☐ Writes
☐ Stammer/stutter/impediment
☐ Speech unclear/slurred
☐ Eye contact
☐ Gestures/aids
☐ Unresponsive

h. Socialization *(mark all that apply):*

☐ Appropriately responds to others' initiations
☐ Appropriately initiates contact with others
☐ Inappropriate responses/interactions *(describe)*: _____
☐ Withdrawn

i. Attitude *(mark one):*

☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

Name: _____

SECTION V- BEHAVIORAL AND PSYCHIATRIC ASSESSMENT (Continued)

2. **Chart of Behavior** *Complete the chart, based on all available information for the last 3 months, including information from the individual's medical records and staff comments:*

	Frequency		Frequency
☐ Dangerous smoking behavior	_____	☐ Destroys property	_____
☐ Refuses medications	_____	☐ Exposes self	_____
☐ Uncooperative diet	_____	☐ Is sexually aggressive	_____
☐ Uncooperative hygiene	_____	☐ Abuses--verbally	_____
☐ Refuses activities	_____	☐ Threatens--verbally	_____
☐ Refuses to eat	_____	☐ Threatens--physically	_____
☐ Self-induces vomiting	_____	☐ Strikes others--provoked	_____
☐ Impatient/demanding	_____	☐ Strikes others--unprovoked	_____
☐ Frequent/continuous yelling	_____	☐ Talk of suicide	_____
☐ Wanders	_____	☐ Suicidal threats	_____
☐ Tries to escape	_____	☐ Suicidal attempts	_____
☐ Seclusiveness	_____	☐ Injures self	_____
☐ Suspicious of others	_____	☐ Other *(specify)*:	_____
☐ Lies purposefully	_____	☐ Other *(specify)*:	_____
☐ Steals deliberately	_____	☐ None	_____

3. **Placement in Seclusion/Physical Restraints/Behavior Change(s)**

In the last 60 days, has the individual been placed in seclusion or other physical restraints to control dangerous behavior?

☐ No ☐ Yes

If "yes," describe the behavior and type of restraints: _____

_____

_____

_____

_____

Comments:

_____

_____

_____

Name: _____

SECTION V: BEHAVIORAL AND PSYCHIATRIC ASSESSMENT (Continued)

4. **Functional Assessment Summary (ICAP, ABS, etc.)**

Describe current functional status - improvement and/or decline. Identify any strengths or weaknesses which may impact the individual's participation in specialized services.

a. Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are fine-motor and gross motor skills.)

b. Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs and requests known. This area also assesses the individual's ability to interact with others.)

c. Personal Living (This domain pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and undressing, etc.)

d. Community Living (This area addresses skills relating to handling money, telling time, acting responsibility, preparing meals, doing laundry, etc.)

e. Broad Independence (This area addresses the individual's overall ability to take care of him/herself and interact in his environment.)

f. Problem Behaviors (Describe any behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that cause harm to oneself. Describe any behavior strategies that have been implemented and their impact on the behavior.)

SECTION VI: DUAL DETERMINATION RECOMMENDATION

1. Name: _____ (Last) _____ (First) _____ (MI)

2. SSN: _____ 3. Medicaid #: _____

4. Does the individual meet the DSM-IV criteria for mental retardation?

☐ No
☐ Yes, check at least one of the following and substantiate by completing item 5 (include copy of assessment)

☐ Mild ☐ Moderate ☐ Severe ☐ Profound

5. Cognitive test (specify): _____ Date performed: _____

Verbal IQ _____ Perf IQ _____ Full Scale IQ _____

Administered by: _____ Title: _____

6. Does the individual meet the DSM-IV criteria for a related condition?

☐ No
☐ Yes, check at least one of the following:

☐ Autism
☐ Blindness
☐ Cerebral Palsy
☐ Deafness
☐ Encephalitis
☐ Epilepsy/seizures
☐ Friedreich's Ataxia
☐ Head Injury
☐ Hemiparesis
☐ Hemiplegia
☐ Hydrocephaly
☐ Meningitis
☐ Microcephaly
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Paraparesis
☐ Paraplegia
☐ Polio
☐ Quadriplegia
☐ Spina Bifida
☐ Spinal Cord Injury
☐ Other; specify: _____

7. Check the box that best describes the individual's functional level in each of the following areas:

	Independent	Minimal	Moderate	Unable
a. Takes care of most personal needs	☐	☐	☐	☐
b. Understands most simple commands	☐	☐	☐	☐
c. Communicates basic needs and wants	☐	☐	☐	☐
d. Is employed at a productive wage w/o long term supervision/support	☐	☐	☐	☐
e. Learns new skills w/o aggressive and consistent training	☐	☐	☐	☐
f. Generalizes trained skills to other environments w/o aggressive and consistent training	☐	☐	☐	☐
g. Demonstrates behaviors appropriate to time, situation, and place w/o supervision	☐	☐	☐	☐
h. Makes decisions requiring informed consent	☐	☐	☐	☐

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION (Continued)

8. SPECIALIZED SERVICES RECOMMENDATION - MR/RC

Does resident require specialized services? ☐ No ☐ Yes **(Mark all that apply):**

CURRENT SPECIALIZED SERVICES		RECOMMENDATIONS		
		Continue	Discontinue	New
☐ 1. Behavior Skills	1.	☐	☐	☐
☐ 2. Communication	2.	☐	☐	☐
☐ 3. Community Living Skills	3.	☐	☐	☐
☐ 4. Resource Utilization Skills	4.	☐	☐	☐
☐ 5. Day Health and Habilitation	5.	☐	☐	☐
☐ 6. Education	6.	☐	☐	☐
☐ 7. Environmental Skills	7.	☐	☐	☐
☐ 8. Pre-Vocational/Sheltered Employment	8.	☐	☐	☐
☐ 9. Self-Advocacy	9.	☐	☐	☐
☐ 10. Self-Help/Personal Care	10.	☐	☐	☐
☐ 11. Social Skills Development	11.	☐	☐	☐
☐ 12. Supported Employment	12.	☐	☐	☐
☐ 13. Task Learning	13.	☐	☐	☐
☐ 14. Transportation to Specialized Services	14.	☐	☐	☐
☐ 15. Assistive Technology Evaluation	15.	☐	☐	☐
☐ 16. Assistive Technology	16.	☐	☐	☐
☐ 16a. Communication devices	16a.	☐	☐	☐
☐ 16b. Compensatory devices	16b.	☐	☐	☐
☐ 16c. Environmental control devices	16c.	☐	☐	☐
☐ 16d. Environmental modifications	16d.	☐	☐	☐
☐ 16e. Feeding devices	16e.	☐	☐	☐
☐ 16f. Wheelchair Seating/positioning	16f.	☐	☐	☐
☐ 16g. Wheelchair fitting-customized	16g.	☐	☐	☐
☐ 16h. Mobility aids	16h.	☐	☐	☐
☐ 17. Other adaptive devices (specify):_____	17.	☐	☐	☐

Rationale: _____

_____

_____

9. SERVICES OF LESSER INTENSITY - MR/RC

Does resident require services of lesser intensity? ☐ NO ☐ YES **(Mark all that apply)**

- ☐ 1. Adjustment needs
- ☐ 2. Basic grooming
- ☐ 3. Behavior management
- ☐ 4. Non-customized durable medical equipment
- ☐ 5. Occupational therapy
- ☐ 6. Physical therapy
- ☐ 7. Restorative nursing
- ☐ 8. Speech-language pathology
- ☐ 9. Sensory stimulation
- ☐ 10. Visual/Hearing
- ☐ 11. Other _____

Print Assessor's Name _____ Title _____ Telephone (___) _____

Assessor/QMRP Signature _____ Date: _____

SECTION VI: DETERMINATION RECOMMENDATION (Continued)

10. As substantiated by your evaluation, does the individual meet the DSM-IV criteria for dementia or a related disorder in the absence of a **primary major mental illness**?

☐ No, continue
☐ Yes, substantiate below, stop here and sign on page 10

Rationale: _____

_____

_____

11. As a result of a major mental disorder, the individual has functional limitations in the following areas (mark all that apply):

a. Interpersonal functioning

☐ 1. Difficulty interacting appropriately/communicating effectively with other persons
☐ 2. A history of altercations, evictions, firing, fear of strangers
☐ 3. Avoids interpersonal relationships
☐ 4. Is socially isolated
☐ 5. Other (specify): _____
☐ 6. None

b. Concentration, persistence and pace

☐ 1. Difficulty in sustaining focused attention to complete work tasks
☐ 2. Difficulty in sustaining focused attention to complete home tasks
☐ 3. Inability to complete tasks within established time period
☐ 4. Makes frequent errors or requires assistance in the completion of tasks
☐ 5. Other (specify): _____
☐ 6. None

c. Adaptation to change

☐ 1. Difficulty in adapting to typical changes associated with work, school or family
☐ 2. Manifests agitation, exacerbated signs and symptoms associated with the illness
☐ 3. Withdraws from the situation
☐ 4. Requires intervention by MH or judicial systems
☐ 5. Other (specify): _____
☐ 6. None

12. As a result of a major mental disorder, the individual has required treatment within the last two years for:

☐ Psychiatric treatment more intensive than outpatient care
☐ Episodes of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officers
☐ None

13. Does the individual meet the DSM-IV criteria for a serious mental illness?

☐ No
☐ Yes, check at least one of the following and substantiate below (P=primary S=secondary)

P	S		P	S	
☐	☐	1. Anxiety disorder	☐	☐	8. Panic disorder
☐	☐	2. Atypical psychosis	☐	☐	9. Paranoid disorder
☐	☐	3. Bi-polar disorder	☐	☐	10. Schizoaffective disorder
☐	☐	4. Delusional disorder	☐	☐	11. Schizophrenia
☐	☐	5. Depression	☐	☐	12. Somotoform disorder
☐	☐	6. Major affective disorder	☐	☐	13. Other *(specify)*: _____
☐	☐	7. Mood disorder	☐	☐	14. Other *(specify)*: _____

Rationale: _____

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION (Continued)

14. SPECIALIZED SERVICES RECOMMENDATION - Mental Illness

Does the individual require specialized services for SMI **(Inpatient psychiatric hospitalization)**?

☐ No
☐ Yes, substantiate below

Rationale: _____

15. MENTAL HEALTH SERVICES RECOMMENDATION - Mental Illness

Does resident require Mental Health Services of a lesser intensity? ☐ Yes ☐ No *(Mark all that apply)*

CURRENT MENTAL HEALTH SERVICES	RECOMMENDATIONS		
	Continue	Discontinue	New
☐ 1. Psychiatric consultation	1. ☐	☐	☐
☐ 2. Behavior management	2. ☐	☐	☐
☐ 3. Day treatment/partial hospitalization	3. ☐	☐	☐
☐ 4. Crisis intervention	4. ☐	☐	☐
☐ 5. Outpatient psychiatric	5. ☐	☐	☐
☐ 6. Psychotropic medication management	6. ☐	☐	☐
☐ 7. Psychosocial rehabilitation	7. ☐	☐	☐
☐ 8. Targeted care management	8. ☐	☐	☐
☐ 9. Other, specify _____	9. ☐	☐	☐

Justification/Comments:

Printed name:_____ Title:_____ Telephone #: ( )_____

Psychiatrist/QMHP Signature:_____ Date:_____